WISCONSIN STATE ASSEMBLY

PEGGY KRUSICK
STATE REPRESENTATIVE

Peggy Krusick's Testimony in Support of SB 538
(Nursing Home Violation Reporting)

Senate Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation
March 3, 2010

Thank you Chairman Carpenter and committee members for the opportunity to testify in support of SB 538.

Right now, a nursing home in Wisconsin can be fined or otherwise sanctioned by the Department of Health Services for violating state rules or regulations if the department determines that a resident's injury or death results from the nursing home's actions—and the family might never know a citation was imposed.

An extensive Milwaukee Journal Sentinel investigation found dozens of nursing homes in Wisconsin had been cited for improper care after the deaths of 56 residents since 2005.

However, according to the report, several families never knew the nursing homes where their loved ones died had been issued violations for serious problems until after the newspaper contacted them.

Following the publication of this investigation, I formed a workgroup consisting of aging advocates, long-term care providers and the Department of Health Services.

SB 538 is the product of those meetings. Essentially the bill would require families to be notified when a nursing home is cited by state regulators if their loved one is included in a serious state citation issued by DHS following an inspection of the nursing home. More specifically:

The Bill
Requires within 15 days of receiving a class "A" violation or a federal finding of Immediate Jeopardy that a nursing home provide written notice to the resident, or to the resident's legal representative, of each resident identified in the citation.

Specifies that the written notice shall include the following:
- The anonymous identifier used to designate the resident in the violation notice.
- Contact information for the Division of Quality Assurance (DQA) regional office assigned to the facility.
- Information that DQA will be able to provide a copy of the citation upon request to the resident or their legal representative.

Provides a maximum $2,500 penalty for nursing homes that fail to comply.

Amendment
During the hearing on the Assembly version of this bill (AB 389), the nursing home and assisted living industry raised some objections to the bill. You will likely hear these objections again today. However,

an amendment has been drafted that I believe adequately addresses their concerns without sacrificing the public good that this bill serves. The amendment has 4 provisions.

1. Limits the reporting requirement to the most serious violations in which substandard quality of care has been identified or actual harm has occurred.
SB 538 requires a nursing home that is cited with a class A violation or a federal finding of Immediate Jeopardy to provide written notice to each resident, or their legal representative, identified in the citation.

Class A and Immediate Jeopardy violations, which are the most severe and least frequent violations cited, are issued when a nursing home's noncompliance with state or federal regulations has caused or is likely to cause actual injury, harm or death. According to the Department of Health Services, class A and Immediate Jeopardy violations comprise less than 4% (206/5,974) of nursing home violations cited in the past 20 months.

In its written testimony, the Wisconsin Health Care Association/Wisconsin Center for Assisted Living (WHCA/WiCAL) presented a hypothetical case of a facility being cited for alleged non-compliance for its response to a gastroenteritis outbreak. WHCA/WiCAL suggests that the bill would require the facility to provide all of its residents a copy of the statement of deficiency (SOD) because the SOD would likely indicate that most or all residents had been exposed to the *potential* for harm.

The amendment addresses this concern by limiting the reporting requirement to Class "A" and Immediate Jeopardy violations in which substandard quality of care has been identified or actual harm has occurred. Nursing homes would not be required to provide residents notice when the facility has been issued a statement of deficiency issued for the potential for harm.

2. Allows a summary of the violation or statement of deficiency to be provided instead.
SB 538 requires a nursing home to provide the resident or legal representative a copy of the written notice of the class A violation or of the statement of deficiency.

In verbal and written testimony provided to the committee, nursing home representatives indicated that some notices of violation or statements of deficiency can be lengthy documents, some even as much as 200 pages in length. The reporting requirements set forth in SB 538 were not originally intended to overburden nursing home providers with excessive paper duplication duties or to flood residents with thick reports they may have no interest in reading.

The amendment addresses this possible unintended consequence by allowing nursing homes to instead provide a summary of the statement of deficiency that contains the exact language used by DHS in the deficient practice statement. Often times this information will fit on one sheet of paper.

3. Extends the time period for notice to be provided.
SB 538 requires the written notice of a Class A or Immediate Jeopardy violation to be provided to the resident or legal representative within 15 days of the violation being issued.

Currently, nursing homes can first contest a state or federal violation through a process called the Informal Dispute Resolution (IDR), which is conducted by a third-party arbitrator. Nursing homes must request an IDR within 10 days of receiving the violation and then the arbitrator must submit a recommendation no later than 21 days from the date the facility received the original violation. Nursing homes also have the right to appeal a violation

Providers have indicated that the 15 day notification deadline in SB 538 may deny facilities their due process rights because a facility may be required to provide a resident notice of a serious violation before the facility has exercised its right to contest the citation.

The amendment addresses this concern to great degree by requiring the written notice of a Class A or Immediate Jeopardy violation (or a summary of the violation) to be provided to the resident or legal representative within 15 days, unless an Informal Dispute Resolution has been requested, in which case the notice would need to be provided after completion of the IDR. The amendment does not extend the notification deadline when an appeal is filed, because appeals can often take months or even years to complete.

It's worth noting that a nursing home is already required to post statements of deficiencies (without identifying information or notice to residents) in its facility. Nursing home deficiency information is also available on the federal Nursing Home Compare Web site. So the argument that SB 538 ignores a facility's due process rights is not wholly accurate, as nursing home violation information is already publicly available before a facility has exercised all of its appeal options. Of course, nursing home residents named in the most serious violations are not currently notified when these violations are issued--which is what SB 538 seeks to remedy.

4. Permits DHS to assess nursing homes a forfeiture for violating the requirements of the bill. The amendment provides a technical change that is necessary for DHS to assess a Class C violation under the bill.

Supporters
AARP Wisconsin
Wisconsin Board on Aging and Long-Term Care
Coalition of Wisconsin Aging Groups Inc
Disability Rights Wisconsin
Wisconsin Coalition Against Domestic Violence
Wisconsin Coalition of Independent Living Centers
Legal Aid Society of Milwaukee
Alzheimer's & Dementia Alliance of Wisconsin
League of Women Voters of Wisconsin

Conclusion
When a nursing home is cited after something very bad happens to a resident, the family has a right to be notified.

This legislation makes citations for serious nursing home violations more transparent and establishes a process for families to easily obtain this information.

Thanks again for the opportunity to testify in support of SB 538. I'd be happy to answer any questions.

State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

Senate Committee on Public Health, Senior Issues, Long-term Care and Job Creation
Wednesday, March 3, 2010

Otis Woods, Division Administrator for the Division of Quality Assurance
Senate Bill 538
Nursing Home Notification Testimony

Good Morning, my name is Otis Woods and I am the Administrator for the Division of Quality Assurance within the Department of Health Services. My agency is responsible for the regulatory oversight of licensed health care facilities for State of Wisconsin and as a federal agent for the Centers of Medicare and Medicaid Services for facilities voluntarily participating in Medicare and Medicaid programs. I wanted to thank this committee and stakeholders in attendance for the opportunity to provide informational testimony on Senate Bill 538.

Wisconsin has 398 nursing homes that are all regulated by the Department. Nursing homes are subject to unannounced inspections at least every 9-15 months, known as full recertification surveys. The Department also performs unannounced complaint surveys.

The goal of the full recertification survey is to evaluate systems, individual resident care, staffing and quality of life to determine if the provider is in substantial compliance with the minimum requirements to be licensed and participate in reimbursement programs. The full recertification survey includes an inter-disciplinary team of DQA staff that includes Registered Nurses, Health Service Specialists (such as a Social Worker, Activity Professionals and Nursing Home Administrators), Engineers as well as access to content experts at our central office, such as a Pharmacist or Registered Dietician. This full survey lasts several days, with some surveys making observations on weekends and all three shifts at the facility.

In 2008, the Bureau of Nursing Home Resident Care received over 1,330 complaints that warranted further investigation; in 2009, we received 1649 complaints that warranted further examination. DQA, Office of Caregiver Quality, also received 1,759 self reports from Wisconsin Nursing Homes in 2009. Complaints and self-reports are reviewed and investigated through the on-site unannounced survey process.

There are five categories for state citations; going from highest to lowest in severity and subsequent enforcement:

1. Class A Violation
2. Class B Violation
3. Class C Violation
4. Correction Order
5. Notation

These violations are defined within Chapter 50. SB 538 addresses Class A violations. Class A violations are issued when "a condition or occurrence relating to the operation and maintenance of a nursing home presenting a substantial probability that death or serious mental or physical harm to a resident will result therefrom." Surveyors can issue a Class A

violation when a resident has been seriously harmed by a deficient practice at the nursing home or when the resident has not yet been harmed but is at substantial risk that serious harm will occur.
Examples of the types of deficient practices that were cited in 2009 at the level of a class A were the following:

- Nurses failed to perform cardiopulmonary resuscitation on residents who had previously indicated a desire to be full code.
- Nurses failed to ensure adequate fluid intake, which caused residents to be hospitalized in comatose states with severe dehydration.
- Staff failed to ensure that residents with dementia and no safety awareness did not wander unnoticed from the nursing home.
- Staff failed to prevent a male resident who had been sexually acting out from raping a bedridden female resident.
- Staff did not follow the approaches that had been developed for preventing falls, which allowed the resident to fall and which contributed to the resident's death.

Class A violations comprise a small percentage of total state violations issued.

- Of 670 state violations issued in 2008, 35 violations (5%) were Class A violations.
- Similarly, of 584 violations issued in 2009, 32 violations (5.5%) were Class A violations.

Federal citations are issued based on the scope, or number of residents that are affected by the deficient practice (Isolated, Pattern or Widespread), and severity of the violation. CMS has 4 categories defining severity of the violation going from highest to lowest and subsequent enforcement:

1. Immediate Jeopardy
2. Actual harm
3. No actual harm with potential for more than minimal harm
4. No actual harm with potential for no more than minimal harm.

These definitions are found in the federal state operations manual. SB 538 addresses Immediate Jeopardy violations, which is "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death."

An Immediate Jeopardy citation would be the highest severity level and could be found in three phases of scope (Isolated, Pattern or Widespread) based on the case specifics. Like Class A violations, surveyors can issue an Immediate Jeopardy citation when a resident has been seriously harmed by a deficient practice at the nursing home or when the resident is at risk that serious harm will occur in the immediate future.

By targeting Immediate Jeopardy violations, this bill applies to a very small subset of all the citations that DQA issues.

- In 2008, our Bureau of Nursing Home Resident Care issued a total of 2,824 federal citations; of these, only 76 (2.7%) violations were identified at the Immediate Jeopardy level.
- In 2009, 2873 federal citations were issued and 79 (again 2.7%) were identified at the Immediate Jeopardy level.

In total, by targeting Class A and Immediate Jeopardy violations, less than 3% of all state and federal violations issued in the past 20 months are impacted by this bill (222/6951).

When any violation is identified, DQA issues a document called the Statement of Deficiency (SOD). The federal contract requires, and internal DQA policy dictates, that a formal and specialized format is used when writing the SOD called the Principles of Documentation. The Principles of Documentation removes the specific identity of staff and resident names involved in any violations. Only the Facility Staff, DQA, and the Centers for Medicare and Medicaid Services are aware of the true identity of the residents involved in the violation.

Federal regulations require facilities to post the SOD in their facilities from the last recertification survey and all subsequent surveys. On average, this would be for the period of one year. The posted SOD does not identify who the residents were.

Current federal and state regulations require nursing homes to notify a family member or designated party when a resident's condition changes. Nursing homes must provide immediate notification of significant condition changes and "prompt" notification of non-significant changes. DQA monitors nursing homes to ensure that such occurs. Current laws, however, do not require nursing homes to inform a family member or designee that *facility practice* caused a serious condition change or placed the resident at risk of serious harm occurring.

SB 538 creates a mechanism to inform residents and legal decision-makers for residents when a resident was specifically involved in a Class A and/or Immediate Jeopardy level rule violation while residing at the nursing home. The SOD would need to be shared with the residents (and or legal decision-makers for residents) identified in the violation or affected by the violation.

SB 538 obligates the nursing home provider community to inform specific residents and legal decision makers for the specific resident, that they were identified as an example of non-compliance for the highest level of state and federal violations as part of the nursing home inspection process conducted by the Department.

This bill also requires nursing homes to include the contact information for the DQA regional office that conducted the survey if they have questions about the SOD or want to know of the final outcome of the survey.

As a minor technical note, SB 538 would need to be modified to permit the Department to assess forfeiture for Class C violations. Currently, DHS does not have statutory authority to assess forfeitures for Class C violations under Chapter 50.

I thank you for the opportunity to provide informational testimony to this important audience. I would be happy to address any questions you have.

WHCA / WiCAL
Wisconsin Health Care Association Wisconsin Center for Assisted Living

To: Senator Tim Carpenter, Chair, and Members of the Senate Public Health, Senior Issues, Long Term Care, and Job Creation Committee

From: WHCA/WiCAL, Brian Purtell and Jim McGinn

Re: 2009 SB 538

Date: March 3, 2010

On behalf of the nursing home members of the Wisconsin Health Care Association (WHCA), the following comments are provided to the proposed 2009 SB 538. The WHCA opposes this bill for multiple reasons, chief among these is the fact that the actions it mandates will do nothing to promote or enhance the quality of care and services provided by Wisconsin's nursing homes. Moreover, the resources that will be expended to meet the bill's expectations will divert already strained staff and resources from resident care.

Notice of allegations is required prior to opportunity for facility to contest and exercise due process rights:

The obligation to provide copies of the Statement of Deficiency (SOD) to residents alleged to be impacted by an Immediate Jeopardy (IJ) deficiency or Class A citation within 15 days of receipt of the allegation is a requirement would obligate such notice without the facility even having an opportunity to refute the allegation. Facilities would not even be able to conduct an Informal Dispute Resolution (IDR), much less a federal or state appeal for an allegation that is disputed, prior to having to provide a copy of and SOD that may contain allegations strongly contested by the facility.

SODs are drafted to support the alleged deficiency, and they are not intended, nor are they drafted, as a balanced depiction of the situation. Further, errors and omissions are made by surveyors, many of which would be modified or eliminated via IDR or administrative appeal. However, in many instances and appeal or IDR may not be pursued because need to allocate facility resources internally, as enforcement regulations compel facilities to focus on satisfying that corrections have been made in order to prevent or cease the imposition of significant penalties.

Compelling a facility to send countless SODs, for which they may strongly contest in whole or in part is counter to the basic notions of due process. The facility reputation and standing will be harmed, and residents/families may be needlessly concerned about

an allegation that may later prove to have been erroneously cited or containing incomplete or inaccurate information.

A likely, but unintended consequence of this bill is that facilities would be compelled to expend resources toward challenging every misstatement or allegations for which they disagree, thus increasing costs to both the providers and the regulators. Further, the already contentious survey process will be further strained by compelling facilities to provide copies of notices for which they disagree.

Compounding the problem further is the fact that IJ allegations can be issued for "the potential" for harm, i.e. alleged non-compliance *could have* lead to harm, but did not occur. Compelling a facility to provide notice to a resident/family, possibly months after the fact, that they were listed within the examples of individual who "might" have been harmed will not serve any purpose and raises the real possibility of causing needless fear or anguish. If for example, a facility was cited for alleged non-compliance related to a facility's response to a gastroenteritis outbreak, the SOD would likely indicate that most or all residents were exposed to the *potential* for harm, regardless of how many or few actually experienced symptoms. Under the bill, it appears that all residents would be required to receive a copy of the SOD.

Regulations currently require extensive notification and/or communication which addresses circumstances better than what SB 538 seeks to address:

The notice requirements contained within SB 538 are duplicative of the existing notification and communication requirements.

Replete through the state and federal regulations, *see,* Wis. Stats Ch. 50, Wis. Admin. Code DHS 132, 42 C.F.R. 483, are reporting/notification expectations by nursing homes, including, but not limited to:

- A facility must immediately notify the resident; consult with the resident's physician, and legal representative/family member when there is:
    - An accident involving the resident which results in injury;
    - A significant change in the resident's physical, mental, or psychosocial status;
    - A need to alter treatment significantly.
- Residents have the right to be fully informed of their health status, including but not limited to their medical condition. This further includes the right to be fully informed in advance about care and treatment and any changes that may affect the resident's well being.
- Conduct care planning sessions with resident and family/representative involvement on an ongoing basis, to discuss such changes or to update a resident's care plan.
- Facilities investigate and report to the DQA, within 24 hours, any allegations involving possible abuse, neglect, misappropriation of property, or injuries of unknown sources.
- Any survey allegation involving possible Substandard Quality of Care (SQC) requires the facility to provide DQA with the names and contact information for the attending physicians of residents possibly impacted. DQA then provides notice to these physicians.

- Unexpected deaths must be reported to the coroner.
- Adhere to the adult-at-risk reporting requirements if any physical or financial exploitation is suspected.

If the purpose of SB 538 is to provide residents and families with information to allow their enhanced dialog with the facility to address care or service concerns, the provision of survey information comes long after expected notification and communications have already occurred. If however, the purpose is to assign blame as to non-compliance, then surely, the facility should be afforded the full opportunity to contest the allegations before being compelled to provide such notice.

All survey results, including IJ and Class A violations, must be posted and are accessible to the public:

Similarly, the state and federal regulations mandate that nursing homes to post survey results and advocacy contact information. Furthermore, there are expanding consumer information resources that report facility compliance history and performance.

- Survey results must be posted in a prominent place within the facility for anyone to review. In addition, CMS continues to enhance its Nursing Home Compare website, which predominantly focus on survey information.
- The Consumer Information Report must be provided to anyone considering placement at a facility or who simply requests the report.
- Notices are required to be provided and posted that residents have the right to receive information from agencies acting as client advocates and be afforded the opportunity to contact these agencies. Residents and their families are provided and encouraged to make contact with advocacy agencies, e.g. the Ombudsman Program, should they have concerns that cannot or have not been addressed by facility personnel.

Pragmatic, Logistical, and Privacy Issues:

There are pragmatic, logistical and privacy concerns for the expectations contained within the bill which requires the nursing home, within 15 days, to provide notice that includes (1) the copy of the SOD, (2) the anonymous identifier used to designate the resident in the SOD, and (3) the contact information for the regional survey office.

This will compel a facility to send multiple versions of what can be a lengthy document that is already posted for review, and available upon request. In some cases, such as an infection control allegation, this may need to go to every resident that was at the facility during the period of alleged non-compliance. As discussed previously, there is already an obligation to notify residents/representatives of changes, accidents, etc. This bill would essentially require further notification of information already possessed and available to residents and their representatives.

To disseminate the anonymous resident identifier along with the SOD will further create a potential privacy issue, as each resident will have to receive a different version, with all the other residents identified being redacted (see attachment as example). While nursing homes are diligent with respect to their privacy and confidentiality obligations, the paperwork required to complete the expected task, coming during the same window in which facilities are expected to be conducting corrective efforts, completing Plans of Corrections, and possibly preparing for IDR/appeal, exposes facilities and residents to needless opportunities for data breaches.

Conclusion:

The above are significant issues and basis for opposition to this bill, but as importantly, the proposed requirements will do nothing to further quality improvement. Compelling facilities to undertake significant workload, at a time when resources are scare and staff should be completing the tasks of addressing the alleged non-compliance, will actually take away from quality efforts. There are already lines of communications that are either required or conducted in the normal course that provides residents and families with opportunities to discuss what may have occurred and what steps the facilities have taken to address issues and concerns. Sending documents that are (1) intended for certification and licensing purposes, (2) possibly months after the fact, and (3) not fully representative of the complete picture, does nothing to towards quality care and will serve only to harm facilities and possibly the residents/family.

For the reasons explained above, the WHCA requires that the committee members oppose SB 538.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Quality Assurance
OQA-2552 (Rev. 01/08)

STATE OF WISCONSIN

STATEMENT OF DEFICIENCIES IDENTIFIER KEY

CONFIDENTIAL - DO NOT POST.

Name - Facility	City - Facility	License / Facility Number
[redacted] Center, LLC	[redacted]	[redacted]
Survey Type	**Exit Date (mm/dd/yyyy)**	**SOD Number(s)**
CHOW, V.V., Entity Self Report; Partial Extended	01/28/09	[redacted]

Resident, Patient, Tenant, or Client (Identify with a number.)		**Staff, Complainant, or Family Member** (Identify with an alphabetical character.)		
Identifier	Name	Identifier	Name	Staff Position or Relationship to Resident, Patient, etc.
[redacted]	[redacted]	NHA	[redacted]	Administrator
[redacted]	[redacted]	DON	[redacted]	Director of Nursing
[redacted]	[redacted]	A	[redacted]	LPN
12.	Ethel [redacted]	B	[redacted]	LPN
[redacted]	[redacted]	C	[redacted]	LPN
[redacted]	[redacted]	D	[redacted]	RN
[redacted]	[redacted]	E	[redacted]	RN
[redacted]	[redacted]	F	[redacted]	Primary MD/Fac.Med.Director
[redacted]	[redacted]	G	[redacted]	RN
[redacted]	[redacted]	H	[redacted]	Corporation's Clinical Nurse
[redacted]	[redacted]	I	[redacted]	CNA
		J	[redacted]	RN

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Wisconsin Association of Homes and Services for the Aging, Inc.

204 South Hamilton Street • Madison, WI 53703 • 608-255-7060 • FAX 608-255-7064 • xww.wahsa.org

March 3, 2010

To: Senator Tim Carpenter, Chair
Members, Senate Public Health, Senior Issues, Long-Term Care and Job Creation Committee

From: John Sauer, Executive Director
Tom Ramsey, Director of Government Relations

Subject: 2009 Senate Bill 538

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership association of 200 not-for-profit long-term care organizations which own, operate and/or sponsor 189 nursing homes, 38 of which are county-owned and operated, as well as 136 assisted living facilities and 113 senior apartment complexes. WAHSA members employ over 38,000 dedicated staff that provides care and services to over 48,000 frail elderly and persons with a disability.

WAHSA members oppose SB 538 and urge members of the Committee to oppose the bill as well.

SB 538 would **require a nursing home** which receives either a state Class "A" notice of violation (NOV) or a federal statement of deficiency (SOD) indicating a finding of "immediate jeopardy" (IJ) (the most serious state and federal nursing home violations) **to provide a written notice to each resident** identified in the NOV/SOD, as well as to the resident's legal representative, if any, within 15 days of the receipt of the violation notice. The written notice to the resident must include a copy of the NOV/SOD, as well as the anonymous identifier used to identify the resident in the NOV/SOD, and the address, telephone number, and email address of the regional office of the Department of Health Services (DHS) Division of Quality Assurance (DQA) in the region where the facility is located. Upon the request of the resident and/or his/her legal representative, SB 538 would require the DQA to provide the resident and/or their legal representative with the final disposition of the Class "A"/IJ **allegations** once the appeals process runs its course. Failure by a nursing home to provide this information is a Class "C" violation, which under s. 50.04(5)(a)3 may subject the facility to a forfeiture of not more than $500. However, under Section 3 of SB 538, the forfeiture level for this particular Class "C" violation would change to not more than $2,500.

Rationale: WAHSA members oppose SB 538 for the following reasons:

- **SB 538 denies nursing facilities their due process rights.** The "written notice requirement" under **this legislation is based on allegations of violations, not on adjudicated findings of violations.** Nursing facilities have the right to challenge the findings of a DQA nursing home survey initially through an informal dispute resolution (IDR) process and, if dissatisfied with that finding, through a formal appeals process (see the attached overview of the IDR/appeals process). The Class "A" or IJ **allegations** which trigger the written resident notice requirement under SB 538 could be reduced to a level below a Class "A" or IJ or even reversed at either the IDR or appeals level, yet those decisions, which would eliminate the need for a written notice, are not taken into account under this legislation.

- Current federal and state notification requirements provide a nursing home resident, the resident's legal representative, if any, and any designated family member with sufficient and timely notification of any significant changes of condition or adverse circumstances affecting the resident. At the September 10, 2009 hearing of the Assembly Aging and Long-Term Care Committee on 2009 Assembly Bill 389, the companion bill to SB 538, the DQA provided committee members with a memo "Applicable Requirements for Communication Between Nursing Home Personnel and Residents/Families/Legal Representatives." That memo listed the following federal/state codes/statutes which require nursing facilities to either "immediately" or "promptly" notify a resident and the resident's legal representative, personal physician, and designated family member(s) of any significant accident, injury, or adverse change in the resident's condition: F-Tags 154, 157 and 168 under 42CFR483.10, s. 50.09(1)(n), Wis. Stats., and DHS 132.60(3)(a) and (3)(b), Wis. Adm. Code (a copy of the DQA memo is attached). **SB 538 is unnecessary if its goal is prompt notification of significant changes in a resident's condition; if the goal is a proliferation of litigation, that's another question.** NOTE: A January 28, 2010 executive session of the Assembly Aging and Long-Term Care Committee was scheduled to vote on AB 389; the executive session was postponed and has not been rescheduled.

- **There is an inconsistency in the issuance of IJ citations throughout the country.** According to survey information compiled by the federal Centers for Medicare and Medicaid Services (CMS), only Alaska, Oklahoma, and New Mexico had a higher percentage of nursing homes receiving IJ citations last year than Wisconsin. In 2009, 7.67% of Wisconsin nursing homes received IJ citations while seven states (Iowa, Maine, Massachusetts, Delaware, Nebraska, North Dakota and Hawaii) and the District of Columbia issued no IJ citations. (See the attached *OSCAR Table Number 5: Percent of Facilities with "Immediate Jeopardy" Citations By HCFA Region, State, and Type of Ownership*, dated 12/09). **SB 538 holds Wisconsin nursing facilities to a standard that is being applied inconsistently throughout the country, unless one believes care provided in Iowa and D.C. nursing homes is significantly better than that being provided in Wisconsin nursing homes.**

- **Survey results, which would indicate whether a facility received either a Class "A" NOV or a federal IJ finding, are required under both federal and state law to be accessible and available.** Under 42CFR483.10(g)(1), a nursing home resident has the right to "examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability." S. 50.04(3)(c), Wis. Stats., requires each nursing home administrator to retain a copy of the most recent biennial report prepared by the DHS and to post "in a place readily visible to residents and visitors, such as the lobby or reception area of the facility, a notice stating that a copy of the report is available for public inspection on request to the administrator." The DHS biennial report lists all conditions and practices in which a facility has not been in compliance with applicable standards within the last 2 years and whether a violation is corrected, contested or subject to an approved plan of correction.

- **Under SB 538, the maximum forfeiture of $2,500 for failure to provide a written notice of a serious violation could in some instances exceed the forfeiture for the serious violation itself.** The $2,500 forfeiture for violation of the written notice requirement under SB 538 equates to a State Class "B" violation, even though Section 3 of the bill describes the failure to provide the required written notification as a Class "C" violation. A Class "B" violation is defined under s. 50.04(4)(b)2 as a violation "which creates a condition or occurrence relating to the operation and maintenance of a nursing home directly threatening to the health, safety or welfare of a resident." Simply stated, failing to notify a resident that a facility has received a NOV/SOD which the facility disagrees with and intends to challenge does not meet the level of "directly threatening the health, safety or welfare" of that resident.

- **Nursing homes view the requirements under SB 538 as a denial of their due process rights and a needless diversion of staff time away from caregiving. If the written notice provision under this legislation is as important as its supporters maintain it is, WAHSA members respectfully suggest the duty to notify residents of these allegations be given to the DQA, which both has made these allegations and compiles the materials in question.**

Thank you for this opportunity to comment on SB 538.

Nursing Home Survey Appeal Process

Given that Wisconsin maintains a dual enforcement system in which providers are subject to sanctions under the federal condition of participation and the state licensing rules, there are separate tracks for appeals when a facility faces both a federal enforcement action following a deficiency and a state enforcement action following a citation. A survey alleging Immediate Jeopardy (IJ) will almost always include an accompanying state citation.

IDR: The first step following a survey involves the option to pursue and Informal Dispute Resolution (IDR). This process is an abbreviated review of the federal deficiency and/or state citation. IDRs are conducted by a third-party contractor, the Michigan Peer Review Organization (MPRO). Within ten days of the receipt of the Statement of Deficiencies (SOD), the facility must both make the request for the IDR and submit the materials to support their position to MPRO. Two copies of the SOD and supplemental materials must be received by MPRO by the tenth day.

Upon receipt of the request for IDR, MPRO schedules the IDR session, if a telephonic session is requested, or begins review if a "desk review" is selected. The telephonic hearing is scheduled to discuss the materials provided and the facility's position as to changes they seek.

MPRO must submit the recommendation to the DQA office as to their recommendation following the IDR session no later that 21 days from the facilities original receipt of the SOD. DQA is to then review the recommendation and provide the facility with its final determination not later than day 24.

Federal Appeal:

If the facility has a federal remedy imposed, i.e. Civil Money Penalty (CMP), Denial of Payment for New Admission (DPNA), etc., the facility has the right to appeal the imposition of the remedy. This appeal must be submitted to CMS no later than 60 days after the imposition of the remedy.

The pace of the appeal process varies somewhat based upon the Administrative Law Judge (ALJ) assigned to the case, but typically involves the establishment of a schedule by the ALJ, which must closely followed by the parties.

If a facility proceeds to a hearing, the final resolution (barring further appeals) will take several months. Exceptions to the typical timetable are recognized for instances where the appeal involves the termination of a provider agreement.

State Appeal:

If a facility receives a state citation, the facility must submit a hearing request to the Division of Hearings and Appeals (DHA) within 10 days of the receipt of the SOD.

While the statutes technically could compel a hearing to be conducted within 30 days of receipt of the request, for efficiency purposes it is routine for providers to waive this timeframe and have the matter held in abeyance until the issuance of the forfeiture.

Many months after the issuance of the citation, the facility will receive the state forfeiture associated with the citation. Upon receipt the facility must again request a hearing for the forfeiture, unless they elect to waive this right and elect the 35% reduction in the forfeiture in exchange for waiving the right to a hearing.

If the appeal is pursued, the DHS Office of Legal Counsel will first conduct a Case Conference with the facility to either narrow the issues to be heard at hearing or explore the potential to resolve the matter without a hearing. If no resolution, the matter proceeds to a hearing. The DHA will establish a hearing date and timeline for parties to complete necessary procedural requirements called for under the scheduling order.

If a facility proceeds all the way to an administrative hearing on a state citation and forfeiture, the process would typically be finalized at least a year after the issuance of the original SOD. Time factors are dependent on the (1) period between the issuance of the SOD and the forfeiture, and (2) the timetable established for the Case Conference and hearing process.

Applicable Requirements for Communication Between Nursing Home Personnel and Residents/Families/Legal Representatives

Federal Rules

42 CFR 483.10

F157. A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)...

F154. The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.

F168. A resident has the right to: Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

State Law Requirements

s. 50.09(1)(n). Every resident in a nursing home or community based residential facility shall...have the right to...(n) Be fully informed of the resident's treatment and care and participate in the planning of the resident's treatment and care.

Nursing Home Administrative Code Requirements

HFS 132.60(3)(a). A resident's physician, guardian, if any, and any other responsible person designated in writing by the resident or guardian to be notified shall be notified promptly of any significant accident, injury, or adverse change in the resident's condition.

HFS 132.60(3)(b). A resident's guardian and any other person designated in writing by the resident or guardian shall be notified promptly of any significant non-medical change in the resident's status, including financial situation, any plan to discharge the resident, or any plan to transfer the resident within the facility or to another facility.

OSCAR Table Number 5
Percent of Facilities with 'Immediate Jeopardy' Citations
By HCFA Region, State, and Type of Ownership

HCFA Region	State	FOR-PROFIT	GOVERNMENT	NON-PROFIT	State Total
Region I	Connecticut	1.06%	0.00%	2.04%	1.25%
	Maine	0.00%	0.00%	0.00%	0.00%
	Massachusetts	0.00%	0.00%	0.00%	0.00%
	New Hampshire	2.44%	0.00%	0.00%	1.25%
	Rhode Island	4.41%	.	0.00%	3.49%
	Vermont	0.00%	0.00%	7.69%	2.50%
		0.85%	***0.00%***	***0.77%***	***0.81%***
Region II	New Jersey	5.44%	8.70%	4.08%	5.28%
	New York	2.17%	9.30%	2.18%	2.66%
		3.57%	***9.09%***	***2.68%***	***3.60%***
Region III	Delaware	0.00%	0.00%	0.00%	0.00%
	District of Columbia	0.00%	0.00%	0.00%	0.00%
	Maryland	1.36%	0.00%	2.60%	1.73%
	Pennsylvania	0.00%	0.00%	0.31%	0.14%
	Virginia	2.66%	0.00%	2.44%	2.49%
	West Virginia	1.14%	0.00%	0.00%	0.78%
		0.99%	***0.00%***	***0.94%***	***0.92%***
Region IV	Alabama	1.67%	0.00%	0.00%	1.30%
	Florida	0.83%	0.00%	0.00%	0.59%
	Georgia	1.27%	0.00%	1.92%	1.39%
	Kentucky	5.34%	0.00%	1.33%	4.18%
	Mississippi	2.88%	3.70%	2.78%	2.97%
	North Carolina	1.27%	0.00%	1.03%	1.18%
	South Carolina	3.79%	11.11%	0.00%	3.95%
	Tennessee	4.13%	0.00%	1.67%	3.46%

Source: OSCAR File as of 12 2009

OSCAR Table Number 5
Percent of Facilities with 'Immediate Jeopardy' Citations
By HCFA Region, State, and Type of Ownership

HCFA Region	State	FOR-PROFIT	GOVERNMENT	NON-PROFIT	State Total
		2.28%	***2.38%***	***0.98%***	***1.98%***
Region V	Illinois	2.34%	3.57%	0.95%	2.02%
	Indiana	1.75%	0.00%	0.70%	1.39%
	Michigan	4.03%	0.00%	1.05%	3.04%
	Minnesota	3.77%	2.27%	3.83%	3.64%
	Ohio	1.64%	0.00%	0.50%	1.35%
	Wisconsin	6.06%	8.62%	9.63%	7.67%
		2.64%	***3.33%***	***2.65%***	***2.69%***
Region VI	Arkansas	2.62%	0.00%	3.45%	2.61%
	Louisiana	3.33%	5.88%	1.82%	3.19%
	New Mexico	8.51%	0.00%	11.11%	8.57%
	Oklahoma	8.86%	27.27%	8.82%	9.49%
	Texas	4.05%	3.45%	2.68%	3.86%
		4.69%	***6.94%***	***3.86%***	***4.65%***
Region VII	Iowa	0.00%	0.00%	0.00%	0.00%
	Kansas	1.20%	0.00%	3.08%	1.76%
	Missouri	4.76%	5.71%	3.31%	4.48%
	Nebraska	0.00%	0.00%	0.00%	0.00%
		2.20%	***1.33%***	***1.56%***	***1.90%***
Region VIII	Colorado	2.05%	0.00%	6.67%	2.86%
	Montana	0.00%	0.00%	2.70%	1.11%
	North Dakota	0.00%	0.00%	0.00%	0.00%
	South Dakota	2.70%	0.00%	1.49%	1.83%
	Utah	1.27%	0.00%	0.00%	1.04%

Source: OSCAR File as of 12 2009

OSCAR Table Number 5
Percent of Facilities with 'Immediate Jeopardy' Citations
By HCFA Region, State, and Type of Ownership

HCFA Region	State	FOR-PROFIT	GOVERNMENT	NON-PROFIT	State Total
	Wyoming	0.00%	5.88%	0.00%	2.63%
		1.56%	***1.61%***	***2.04%***	***1.75%***
Region IX	Arizona	1.90%	0.00%	0.00%	1.48%
	California	3.37%	2.17%	1.01%	2.96%
	Hawaii	0.00%	0.00%	0.00%	0.00%
	Nevada	5.56%	0.00%	0.00%	4.08%
		3.24%	***1.56%***	***0.82%***	***2.76%***
Region X	Alaska	33.33%	0.00%	16.67%	13.33%
	Idaho	9.62%	7.14%	0.00%	7.59%
	Oregon	5.45%	0.00%	0.00%	4.38%
	Washington	1.78%	0.00%	0.00%	1.29%
		4.49%	***2.33%***	***1.15%***	***3.66%***

[redacted]

Source: OSCAR File as of 12 2009

Introduction to Plan of Correction

Rock Haven residents, families and staff,

As I write this plan of correction, I cannot help but be disappointed that we have any incidents where residents were injured at our facility. It is our sincere desire that all residents be safe in their home. Unfortunately, accidents happen daily in all settings, particularly with the frail elderly and we are no different.

I am also disappointed that Rock Haven has joined over 40 other Wisconsin nursing homes in receiving survey citations at the immediate jeopardy level in 2009. Immediate jeopardy citations are given when the surveyors believe that the facility's actions place the resident at risk for great harm, even death.

Wisconsin immediate jeopardy citations are so frequent, that we now rank fifth in the nation in this area. For most readers, this would lead you to assume that Wisconsin nursing homes, including Rock Haven provide poor care.

I know that in our case, this is not true. An isolated event that did not go as well as we would have liked has placed us in this unfortunate situation. In spite of the fact that we immediately reviewed this situation and believe that we have systems in place to prevent a recurrence, both the State and Federal governments are citing us.

We took these situations very seriously, looking at nursing assessment and decision-making, physician notification and fall prevention. Both situations were reviewed by nursing management, Senior Management Team, Safety committee, Quality Assurance committee and with our medical staff at their quarterly meeting.

Today, Federal and State nursing home regulations hold nursing homes to a standard that seems impossible for even the best of nursing homes to meet.

Sadly, compliance with State and Federal regulations becomes a huge burden for all facilities, taking our focus off quality care and placing it instead on surveys and the resultant penalties.

Once again, both the Federal and State governments are fining us. The cover letter that I received stated that the financial situation of the facility is taken into consideration when assessing fines.

If that were the case, we would never be fined. Over 90% of our residents receive Medicaid. Our Medicaid rate pays 50% of the actual cost of care at our facility.

Rock County taxpayers contribute over 6 million dollars annually to Rock Haven in order for us to continue to provide care to frail and elderly Rock County citizens.

As we prepared our 2010 budget request, we had to adjust to annual Medicaid cuts totaling $500,000 and an expected $35,000 loss in Medicare funding due to adjustments to the Rock County labor region.

As you read through the survey document, you will read the surveyor's concerns and comments in the left hand column and my comments in the right hand column.

The survey visit did not go well. We could not defend ourselves in a manner that was satisfactory to the surveyors. There seemed to be an inaccurate conclusion that we ignored the situations and that we have systemic problems with physician notification and nurse assessment and decision-making. I disagree with both conclusions.

Please feel free to contact me if you have questions about this survey or about Rock Haven.

Sherry Gunderson RN, BSN,
Nursing Home Administrator

F 157 Physician Notification

This Federal nursing home regulation, *F 157 Notification of Changes* holds nursing home staff accountable to keep physicians and family members informed of changes in resident status.

It is our policy that all incidents/injuries be reported to the physician and to the resident's family member or guardian. We have incorporated the American Medical Directors Association Guidelines for Physician Notification into our policy.

The AMDA guidelines assist the RN to prioritize calls. The AMDA guidelines related to change of condition assist the RN to thoroughly assess the situation prior to MD notification. These guidelines also encourage nurses to use professional judgment when making decisions about the nursing assessment and care to be provided.

All of the AMDA guidelines are included in our Nursing Policy and Procedure manual. Our nurses have become familiar with the guidelines through the use of a structured self-study packet. We have used this format to introduce the Physician Notification, Change of Condition, Dementia and Delirium and Common Infections guidelines to our nurses.

As a result of this complaint survey, the surveyors are citing us for two unfortunate resident incidents that they agreed were both unpredictable and not preventable. The survey focus was the care and treatment of a serious head injury. Resident 1 had a serious head injury, Resident 5 did not and I disagree with the inclusion of that resident's incident in these citations.

Corrective actions for the resident found to have been affected:

Example 1

Resident 1 suffered an unwitnessed fall at 4 am on 5/26/09. Staff was alerted to the fall when they heard a loud thump. Resident 1's room is 2 doors from our central nurses' station area and staff responded promptly to her room. The nursing assistants entered the room first.

Resident 1 was lying on the floor, face down. She did not respond to their questions. The RN and nursing supervisor immediately followed. They carefully assisted Resident 1 to roll over. She appeared dazed but within a few seconds was answering the RN's questions. Based upon the CNA statement that Resident 1 didn't respond when her name was called, the RN had to assume that there was a brief loss of consciousness.

Resident 1 was assessed carefully. Her blood pressure was higher than her normal, her pupils were equal with equal reaction to light and she was able to move all extremities. She was developing a hematoma on the left side of her head and was able to report that her head hurt. She was also able to tell staff that she didn't like ice on her head.

The RN assigned staff to stay with Resident 1 and when the resident said that she wanted to get up, she was brought to the center area to sit with a staff person.

Resident 1's headache was treated with Tylenol, ice was applied to the hematoma and Resident 1 was given Lorazepam for anxiety.

5

Night staff was very familiar with Resident 1 as it is her habit to stay up late and then sleep in. They also see her anxiety on a nightly basis as she often worries about getting home or her children.

Vital signs and neuorological status was reassessed at 4:10 am, 4:40 am, 5 am, and 6:30 am. Both the staff RN and the nursing supervisor found the resident to be stable, her blood pressure had returned to her baseline, she was comfortable sitting with staff and her headache had lessened. They felt comfortable having the physician see Resident 1 on morning rounds, but did plan to notify the physician if there was a change in her status.

Example 1

When the day shift RN arrived at 6 am, she received report and reassessed Resident 1 at 6:30 am, 7 am , 8 am and 8:20 am. She was concerned about Resident 1 and contacted the physician when Resident 1 complained that her headache was worse and then had an emesis. Resident 1 was transported to our local emergency room.

Resident 1 remained stable during paramedic transport and while in the ER. A CT scan was completed indicating a subarachnoid hemorrhage. Because Resident 1 was stable and back to her baseline, she was a candidate for medical management. It was decided that she would benefit from an admission to the neurological ICU at UW hospital.

The helicopter was available and at 12:30 pm, she was transported via med flight. Her trip was uneventful. She didn't like being confined in the helicopter and they gave her a sedative to calm her.

She was stable throughout her stay at UW, requiring only medical management. A repeat CT scan showed only minimal blossoming of the subarachnoid hemorrhage. She never experienced a change in neurological status. She was medically managed with Thorazine and Lorazepam to keep her calm.

By 5/27, she was up walking with her walker and her son. She returned to Rock Haven on 5/29/09.

We were cited at an immediate jeopardy level because it is always possible that a delay in diagnosis and treatment of a brain injury could lead to a person's death.

The nurses involved in this situation also recognized that possibility. For that reason, the RNs monitored Resident 1 closely, recognized the need to keep her calm and treated her symptoms. They also provided 1:1 staff attention.

Example 1

We reviewed this incident on 5/26 and agreed that the physician should have been notified earlier. The Director of Nurses met with the night RN and supervisor to review the incident. I met with the day shift RN and supervisor and discussed this incident with nurses throughout the facility over the few days following the incident. I also met with nursing supervisors to reinforce their responsibility in incidents such as this. That message was repeated at their next nurse managers' meeting.

I discussed the incident with Dr. Rao, our Medical Director and with all of the physicians at their quarterly medical staff meeting. None of the physicians reported concerns with nurse notification of incidents. All agreed that this was an isolated event.

As part of our Quality Assurance process, we track and trend all incidents and injuries. Over the 3 months (April through June 2009), our staff completed 149 incident reports. Of those, 58 incidents did not result in resident injury. Of the remaining 91 incidents, 83 involved a minor injury such as a bruise, 6 involved a significant injury such as a larger bruise and only 2 involved a major injury.- Residents 1 and 5.

The nursing supervisor, nursing management and the NHA, reviewed all 149 reports and make care plan changes and took preventive measures where warranted.

MD notification (time and method) is also tracked via these QA tools. We have not identified a systemic concern and believe this to be an isolated incident.

At the time of this isolated incident, we also focused our attention on how the fall happened and what we could do to prevent a similar incident for any other resident.

Resident 1's room was rearranged and furniture removed to make a clear path to the bathroom. The bathroom door was removed and a privacy curtain applied.

At that time, we did review the issue of physician notification with the RNs involved in this incident. It was our belief that all realized that the physician should have been notified immediately.

This issue was also discussed with the both the night and day shift RNs at their annual evaluation. The need for prompt physician notification was reflected on their evaluations.

The surveyor questioned why the nurses were not disciplined. I explained that this was the only incident in the entire year where any of these RN's decisions were questioned; therefore progressive discipline was not warranted.

I spoke with the nursing supervisor involved in the incident. Retrospectively, she did understand that physician notification sooner rather than later was preferable with any head injury. This incident will also be reflected on her annual evaluation.

With review of this incident:

We did realize the concern regarding prompt MD notification. We hold our nurse managers accountable to assist RNs to make these decisions. That accountability was reinforced with the nurse manager group.

We also carefully review all incident/injury reports including the time and method of physician notification and have not identified any concern in this area. This lack of timely notification was an isolated incident. Our Medical Staff confirmed this conclusion.

Example 2

Resident 5 was added as an example to our survey citation to prove the point that the action that we took after the 5/26 incident was not sufficient to protect other residents. I disagree. Comparing these two incidents is like comparing apples to oranges. Resident 5 did not have a serious head injury. She bumped her forehead on the corner of a dresser sustaining a skin tear. This incident is not evidence of a systemic problem with physician notification.

In the case of Resident 5, two staff RNs and the nursing supervisor assessed her at the time of her fall. The skin tear to her head was a well-approximated wound that was appropriate for steri strips.

In compliance with our Physician Notification Guidelines, this wound did not warrant immediate physician notification. We have a long-standing skin tear protocol in place at our facility and the nurses followed that protocol. This skin tear could have appropriately been cared for with steri-strips or any of the skin glues.

This was not a wound that warranted suturing and sutures would not have been applied if she had not gone to the emergency room to evaluate a complaint of leg pain that developed after return to bed. I expect that a resident on duty in the ER that evening wanted experience in suturing.

The nurses notified the physician appropriately, at the time that the resident reported new pain in her leg.

This incident was reviewed with the RNs and nursing supervisor involved. Facility policy was followed and no corrective action was warranted.

How the facility has/will identify other residents at risk:

All of our residents are at risk to experience incidents with injury, acute illness or other changes that warrant physician notification.

The RNs decision to notify the physician is based upon his/her assessment of the situation and the guidance provided in our *Physician Notification Guidelines.*

Residents whose health status requires physician notification will be identified through the 24-hour report sheet, face to face report between the RN and the nurse manager each shift, nurse manager email report and the physician notification form/round book.

In addition, nurse managers are notified of all injuries/incidents and have the opportunity to identify at-risk residents through this review process each shift. As mentioned, all incident/injury reports are reviewed through our Quality Assurance process.

What measures have/will be put into place to prevent recurrence:

I reviewed our *Physician Notification Guidelines* with Dr. Rao, Medical Director and further guidance was given to nurses regarding physician notification in the case of episodes of unconsciousness. Copies were posted on all units and placed in the front of the medex.

Nurses' inservices were held 7/29 through 8/2 to review the *Neurological Assessment Policy, Neurological Assessment Tool* and the *Physician Notification Guidelines.*

A traveling display board discussing head injuries was circulated throughout the facility for all direct caregivers.

In additions, nurses' meetings were held on August 3rd and 5th to discuss the survey concerns with all nurses. Information from both meetings was reviewed with nurses returning from vacation prior to their first shift of duty.

Our *Neurological Assessment Policy* was updated to include timeframes for neurological assessments post head injury- every 15 minutes x 4, every ½ hour x 4 and then every shift for a total of 72 hours. In addition a *Neurological Assessment Tool* was created to make documentation of the neurological checks easier. The tool was put into place 7/30. Copies of the policy were placed in all communication books and in front of the medex.

Both incidents were discussed with nurse managers immediately following the incidents and again at our July 6th manager's meeting.

We reviewed the nurse manager's role in resident assessment and physician notification. Nurse managers are expected to immediately respond to significant resident injuries and are held accountable to mentor the nurses to assure that our Neurological Assessment policy and Physician Notification Guidelines are followed.

How the facility will monitor to ensure that the deficient practice is corrected and does not recur:

Nurse failure to complete these tasks will result in disciplinary action. Both unions were notified of that plan.

I reviewed these incidents with our Medical Director, Dr. Rao at the time of the incidents. The incidents were reviewed with all physicians at our July 22nd quarterly Medical Staff meeting. I wrote to our Medical Staff post survey visit and included copies of the updated guidelines and Neurological Assessment policy.

The nursing supervisor, DON or ADON and the NHA, review all injury/incident reports. The data from our reports is entered into a database that gives us the opportunity to run reports to review trends on each unit and house wide. We reviewed over 600 reports over the past 12 months and have not identified any concern with physician notification. The incident on 5/26 was an isolated incident.

Nurse managers will be completing audits every shift to ensure that any actual or suspected head injury was treated appropriately, neurological checks were completed timely and per policy, the MD was notified per policy and that care plans have been updated to reflect health concerns.

In addition, nursing supervisors will be auditing nursing documentation related to resident changes of condition to assure that nurses are complying with our Physician Notification policy.

Once nurse managers feel certain that staff nurses are compliant with this process, audits will be completed at intervals throughout the year. This process will be tracked through our Quality Assurance Program with Ginger Katzman, Director of Nurses responsible for compliance.

Compliance date: August 10, 2009

S 395 132.60 Resident Care/Basic Nursing Care

This Wisconsin nursing home code holds the RN, charge nurses accountable to take appropriate action when caring for a resident with a change of condition. Appropriate action includes nursing assessment, nursing care and communication with the physician and family.

In the case of the two residents cited in this survey, the nursing assessment and care was appropriate to the situation. For Resident 1, we agree that more prompt physician notification was warranted because of the seriousness of the head bump. We also recognize that the RN assessments were timely, the appropriate care was given to Resident 1 to treat her headache and anxiety and that Resident 1 had constant staff monitoring from the time of incident until her transfer to the ER.

In the case of Resident 5, the nursing assessment, nursing care and physician notification were appropriate to the situation.

It is our policy that all incidents/injuries be reported to the physician and to the resident's family member or guardian. We have incorporated the American Medical Directors Association Guidelines for Physician Notification into our policy.

SCOPE / SEVERITY/HARM	ISOLATED *(One or a very limited number of residents affected and/or one or a very limited number of staff involved, and/or the situation occurred only occasionally or in a very limited number of locations.)*	PATTERN *(More than a limited number of residents affected, and/or more than a limited number of staff involved, and/or the situation occurred in several locations and/or the same resident(s) have been affected by repeated occurrences of the same practice.)*	WIDESPREAD *(Situation was pervasive throughout the facility or represented a systemic failure that affected or had the potential to affect a large portion or all of the facility's residents.)*
(4) Immediate jeopardy to resident health or safety *(Deficient practice caused or is likely to cause serious injury, serious harm, serious impairment or death AND there is a reasonable degree of predictability of a similar situation occurring in the future. Immediate corrective action is needed.)*	J	K	L
(3) Actual harm that is not immediate jeopardy *(Deficient practice led to a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well-being...)*	G	H	I
(2) No actual harm with potential for more than minimal harm that is not immediate jeopardy *(Deficient practice has led to minimal physical, mental, and/or psychosocial discomfort to the resident and/or a yet unrealized potential for compromising the resident's ability to maintain and/or reach his/her highest practicable level of physical, mental, and/or psychosocial well-being...)*	D	E	F
(1) No actual harm with potential for no more than minimal harm *(Deficient practice has the potential for causing no more than minor negative impact on residents.)*	SUBSTANTIAL COMPLIANCE A	SUBSTANTIAL COMPLIANCE B	SUBSTANTIAL COMPLIANCE C

SHADED AREAS = SUBSTANDARD QUALITY OF CARE for any deficiency in s. 483.13 Resident Behavior and Facility Practices (F221-F225), s. 483.15, Quality of Life (F240-F258), and s. 483.25 Quality of Care (F309-F333).

*** If the examples under one tag are at different levels of harm, choose the HIGHEST harm level and the scope associated with that particular level of harm.

Wisconsin Association of Homes and Services for the Aging, Inc.
204 South Hamilton Street • Madison, Wisconsin 53703 • 608-255-7060 • FAX 608-255-7064

Fact Sheet: Medicaid Underpayment for Resident Care

A comprehensive analysis of the nation's Medicaid nursing home payment systems ranked the Wisconsin system the worst in the country. The study, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care" released in November 2009 by Eljay, LLP, accountants and consultants, revealed that Medicaid deficits sustained by Wisconsin's nursing facilities are the highest in the country or twice the national average (loss per nursing home resident/day).

The national report and ranking came as no surprise to the Wisconsin nursing home community. Indeed, the Wisconsin Medicaid program's own database of facility- specific cost and reimbursement information vividly illustrates the system's inadequacies. It reveals the following:

- Medicaid recipients as of January 2010 (20,450 residents), including Family Care enrollees, comprise approximately 65% of all residents served in Wisconsin nursing facilities (31,461 total residents). Source: Bureau of Nursing Home Resident Care, Division of Quality Assurance, January 2010

- Labor costs represent approximately 73% of the total cost of providing care and treatment to nursing home residents. Nursing homes employ over 50,000 individuals; 60% of all nursing home personnel perform nursing care and services (RNs, LPNs, and certified nursing assistants).

- In the 2008-2009 payment year, the difference between the total cost of the care facilities provided their Medicaid residents and the Medicaid reimbursement they received for providing that care (i.e., the "Medicaid deficit") was $285,592,212*.

- Direct care costs, the costs to provide hands-on care to residents, represented $167,735,392*, or 58.7%, of the total costs Medicaid failed to reimburse in 2008-2009.

- Approximately 97% of the 369 nursing facilities in the state's database received a Medicaid payment in 2008-09 which failed to meet the cost of care they provided their Medicaid residents.

- Wisconsin nursing facilities on average lose $40.39* per day for each Medicaid resident they serve. For the average Wisconsin nursing home, that results in an annual loss of $795,521* to provide care to its Medicaid residents.

- As a result of the failure of the Medicaid program to pay the resident care costs for which it is responsible, private paying residents are compelled to pay rates that average nearly $73 per day higher than a facility's Medicaid payment rate (Average 2008-2009 Medicaid payment rate: $139.52 per day). It is these private pay residents, who currently are required to pay the $150 per month nursing home bed tax, who are being asked to subsidize this Medicaid underfunding.

**Excludes Family Care related losses*

Alzheimer's & Dementia Alliance
OF WISCONSIN

March 3, 2010

By: Rob Gundermann, Public Policy Director Alzheimer's and Dementia Alliance of Wisconsin.

Good morning Chair Carpenter, members of the committee, and thank you for the opportunity to speak today. I'm Rob Gundermann here on behalf of the Alzheimer's Alliance in support of SB 538.

We feel this bill provides important protections for people with dementia. Dementia is an irreversible disease of the brain which as it progresses steals the person's ability to communicate. This puts people with dementia at a considerable disadvantage when it comes to advocating for their own care. If something bad happens to someone with dementia they often can't tell anyone about it. Forty-seven percent of people in nursing homes have some form of dementia and with it varying degrees of cognitive impairment. So what we have are two groups of people, one who can speak for themselves and can report problems with their care to a family member or guardian and another group who cannot.

We believe that SB 538 helps to level the playing field for people with dementia by ensuring that the family or guardian of every nursing home resident who is cited in an immediate jeopardy or class "A" violation is aware of the violation and not just those families and guardians who are fortunate enough to be caring for a resident who can speak.

We also believe that by requiring facilities to disclose **only** when a class "A" or immediate jeopardy citation has been issued either because of substandard care or actual harm this bill doesn't impose an undue hardship on the industry.

Last night I was reading through some of the citations issued recently. In one case a mildly confused resident with an activated power of attorney for health care laid outside in the rain in 37 degree weather for approximately 3 hours before staff realized that the resident was missing. If this were my mom or dad or my spouse and I was their guardian I would feel that I had the right to know this happened.

Thank you for your time and consideration.

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STATE OF WISCONSIN
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TESTIMONY
of William P. Donaldson.
Counsel to the Board on Aging and Long Term Care
In Support of SB 538

Thank you, Sen. Carpenter and members of the Committee for listening to the comments of the Board on Aging and Long Term Care (BOALTC) on this important bill.

The Long Term Care Ombudsman Program operated by BOALTC has, as a significant part of its functional mandate under state statutes and the federal Older Americans Act, a responsibility to educate and inform residents of long term care facilities and their families about issues of concern to them. Over the years, these issues have primarily focused on residents' rights and concerns relating to regulatory activities in the resident's home.

Residents and their families often specifically inquire about the survey process. They want to know where they can find the results of that process (the Statement of Deficiency [SOD]), and how to interpret that document. In many cases, the families are surprised and even outraged that they are hearing a detailed description of an event involving their loved one for the first time. The families sometimes indicate that they have been told that "something happened," or that "there was a little mishap," or that "Dad fell out of bed when no one was there." However, these stories lacked the detail that was made available to the investigators and, in some cases, there is little resemblance at all between the information given to the family and the investigation report. This is wrong and the "smoothing over" of events that cause harm or may cause harm to residents cannot be allowed to be the norm.

A fundamental premise of the Long Term Care Ombudsman Program is that transparency is a basic right of residents. This agency believes that this transparency extends to all aspects of a resident's life in the facility. It has been our position, developed from experience, that the appearance of a cover-up caused by a lack of disclosure of all of the details of an unfortunate event until after a DQA investigation has been completed presents a serious issue for a family. This lack of honesty may actually do more to arouse a family's suspicion and resentment than will an honest, straightforward and complete discussion of the incident and ways to avoid its recurrence.

In any event, we believe that it is the right of residents and their family members to have timely notice that the resident has been at the center of an investigation by the regulatory authority of the state and to know the cause and the outcome of that investigation as soon as possible. SB 538 will do much to achieve this result.

Thank you for your attention. At this time I would be happy to answer any questions that the Committee may have.

disabilityrights | WISCONSIN

March 3, 2010

To: Senator Tim Carpenter, Chair, and Members, Senate Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation

From: Lynn Breedlove, Executive Director

Subject: Support for SB 538, Nursing Home Violation Reporting

Disability Rights Wisconsin (DRW) is the designated protection and advocacy agency for people with disabilities in Wisconsin. In that role, we provide individual advocacy to a substantial number of nursing home residents (and residents of specialized nursing homes known as ICF/MRs) every year. In our experience, we have noticed that the large majority of residents and their families are unaware of both their rights as a nursing home resident and the specific violations that have been found in their facility.

We believe strongly that one major thrust of long-term care reform in Wisconsin should be an increase in transparency, accountability, and consumer empowerment in the system. Consumers and families should have ready access to the understandable information they need to make informed choices and to advocate for themselves. This is particularly important in the context of choosing a nursing home, advocating for yourself (or for a family member residing in a nursing home) or for deciding whether to move out of a nursing home, in light of the fact that some nursing homes in Wisconsin have had a substantial number of violations.

We consider SB 538 to be an important positive step in increasing transparency, accountability, and consumer empowerment. We encourage you to support it.

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